



## AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: \_\_\_\_\_ SSN #: \_\_\_\_\_

Company Name: \_\_\_\_\_ Branch/Store #: \_\_\_\_\_

Work Related: Date of Injury \_\_\_\_\_ Body Part \_\_\_\_\_ New Injury Follow Up

Can Medications Be Dispensed? Yes OTC Only No

### PHYSICAL EXAMINATION

Pre-employment Annual DOT RTW Other: \_\_\_\_\_  
Fit For Duty Respiratory Clearance Silica/Asbestos OSHA Questionnaire

### SUBSTANCE ABUSE TESTING

DOT 5 Panel (send out to Lab) 5 Panel Rapid Breath Alcohol Test (BAT)  
5 Panel (send out to our Lab Alere) 10 Panel Rapid DOT Non-DOT  
10 Panel (send out to our Lab Alere) Urine Collection only (Client provided CCF) Hair Follicle Test

### REASON FOR SUBSTANCE ABUSE TESTING

Pre-employment Reasonable Suspicion Post-Accident  
Random Return to Duty (RTD) Follow Up

### ADDITIONAL SERVICES

Audiometry TB Skin Test PFT (Spirometry) EKG Lift Test 50 lbs. or 75 lbs.  
Vision Screening Agility Test X-Ray (1 View) COVID Other: \_\_\_\_\_

### BILLING

Employer Paid

Insurance Carrier/TPA

Employer Name: \_\_\_\_\_ HR/Safety Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

Workers Comp Carrier Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

### AUTHORIZER'S INFORMATION (REQUIRED)

Authorized by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Verified by: \_\_\_\_\_ (Staff Member) Date: \_\_\_\_\_